Abstract:

Purpose – Multidisciplinary team (MDT) clinical supervision is being used in many mental health services but at present has not received adequate attention by researchers in order to generate evidence based approaches. This paper aims to explore the utility and staff perspectives of an MDT model of clinical supervision in the form of a "Clinical Discussion Group" (CDG) on an acute inpatient mental health ward within the context of the current literature on the components of effective supervision in order to make recommendations for practice.
Design/Methodology/Approach – Twelve members of staff working on the ward were interviewed to gather their perspective on attendance, helpful aspects, outcomes, unhelpful aspects, and changes. Interview transcripts were analysed using thematic analysis.
Findings - Eleven themes were identified, three within "The Group and how it operates" (Attendance, Discussion Topics and Facilitation), five within "Impact and Usefulness" (Valued by Staff, Understanding a Case, Emotional Benefit, Learning and Working together as a Team) and three within "Changes to the Group" (Organisation, Discussion Topic and Group Outcomes).
Originality/Value – This paper explores the benefits and challenges of a CDG from the perspective of the staff who attend. It presents some recommendations for good practice which should be of use to managers and supervisors who wish to use team supervision to improve patient outcomes and also makes suggestions for future research in this field.

Clinical supervision, henceforth referred to as supervision, is the oversight of practice, and may be more specifically defined as "the formal provision by senior/qualified health practitioners of an intensive relationship-based education and training that is case focussed and which supports, directs and guides the work of colleagues" (Milne, 2007). Staff working on inpatient psychiatric (or mental health) wards have access to several formats of supervision including formal group or individual case discussions, managerial, case conferences, handovers, daily reviews and peer discussions (Buus et al., 2011). Clinical Psychologists are well placed to provide supervision within staff teams, a position which is recognised by various government and professional body documents (British Psychological Society, 2001, National Institute for Mental Health in England, 2007). Multidisciplinary team supervision offers an opportunity for members of different professions to work together to enhance the quality of patient care (Mullarkey et al., 2001).

The purpose of clinical supervision

Proctor (1987) proposed a framework for supervision incorporating three key functions: formative, normative and restorative. This framework has been used to shape supervision structure and direct further research. Formative benefits include a broader knowledge base rather than a solely neurobiological understanding of mental health (Crowe et al., 2008), increased creativity (Brunero and Stein-Parbury, 2008) and a lasting influence on professional confidence (Arvidsson et al., 2008). Normative benefits have been found to include increased empathy (Brunero and Stein-Parbury, 2008), autonomy (Hallberg et al., 1994) and improved cooperation between staff and patients (Severinsson and Hallberg, 1996). The restorative effects of supervision have been most commonly researched, indicating that supervisees experience less strain and burnout (Hallberg and Norberg, 1993, Berg et al., 1994, Edwards et al., 2006, Hallberg, 1994, Hyrkas, 2005), improved coping (Berg and Hallberg, 1999) and are more able to maintain their strength and energy (Arvidsson et al., 2008).

Components of effective supervision

In a review of empirical studies, Buus and Gonge (2009) concluded that methodological weaknesses in the available literature allowed for only tentative conclusions regarding the effectiveness of supervision. The research that is available relies upon small sample sizes, has insufficient consideration of confounding factors and often uses qualitative accounts of supervisees' perspectives. The following components have been discussed as being important: length and frequency of sessions; session content; supervision environment; supervisee involvement, preparation and follow-up (Table 1).

<table 1 here>

Barriers to effective supervision

Barriers to effective supervision include supervisee beliefs that supervision will increase their stress and be anxiety provoking, uncertainty about the confidentiality, feeling threatened and finding it to be unproductive (Butterworth et al., 2008). Furthermore, the nature of shift work makes it difficult to achieve regular attendance (Buus et al., 2011) and professionally trained staff are more likely than unqualified staff to attend case formulation sessions (Summers, 2006), perhaps due to hierarchies within teams or greater perceived ability to contribute.

Psychological Formulation in Teams

One format of team supervision explored recently in the literature takes the form of psychological formulation within teams. A psychological case formulation is an attempt to understand an individual's difficulties by drawing upon psychological theories to explain why they have developed these difficulties at this time and in these situations in order to generate a plan of intervention (Johnstone and Dallos, 2006). Various authors have described innovations and case examples of team formulation from a range of different perspectives (Christofides et al., 2012) including Cognitive-Behavioural (Lake, 2008, Kennedy et al., 2003, Dexter-Smith, 2010), Psychodynamic (Davenport, 2002), Attachment (Lake, 2008) and Systemic (Martin and Milton, 2005). This approach lends itself particularly well to addressing many of the purposes of clinical supervision identified above including expanding knowledge through education and training; focusing on care by helping to select and guide interventions; increasing empathy though improved understanding; and reducing strain and burden by improving team cohesion.

However, this approach has been recognised as particularly challenging as although it is possible to create an environment to share problems, open communication and slow progress can create tensions in the team (Hyrkäs and Appelqvist-Schmidlechner, 2003). The challenges of working in this way are reflected by the lack of empirical research into clinical outcomes of team supervision, so the implementation and evaluation of such groups is an important area for research.

Aim

This study aimed to explore the extent to which the evidence based components of effective supervision were met by a multidisciplinary "Clinical Discussion Group" (CDG) on an acute inpatient mental health ward.

Method

Ethical Considerations

This study was reviewed and approved by the University of Bath Department of Psychology Ethics Committee and the local NHS trust Research and Development Department.

Description of the Service

The acute inpatient service provides mental health care to adults whose needs are complex, intense and unpredictable. The multidisciplinary staff team consisting of medics, nurses, health care assistants, occupational therapists, psychologists and art therapists provide evidence based interventions within a recovery model of care. Supervision takes the form of a "Clinical Discussion Group" (CDG) facilitated fortnightly by a Clinical Psychologist.

The CDG aims to provide time and space for staff to talk about clinical cases, and to increase psychological thinking. This is achieved through conversations between staff members facilitated by the psychologist who tries to pull together the information, introduce psychological models and encourage problem solving and interventions for the staff to take forward. These sessions take place fortnightly during an extended handover period between shifts, lasting 45 minutes.

Participants

All members of clinical staff were invited to take part in the study. Twelve participants (nine female, three male) were recruited in total from a diverse range of profession including six nurses, four Health Care Assistants, one Occupational Therapist and one Medic.

Procedure

Staff were invited to participate in an individual interview via email, poster advertisement and by the primary author (SD) in person. Informed consent was obtained prior to participation. Interviews took place in private rooms within the inpatient ward, lasted fifteen to thirty minutes and were conducted by SD.

Data was collected using a semi-structured interview schedule focused on five areas: attendance; helpful aspects; outcomes; unhelpful aspects; and changes. The interviews were digitally recorded and transcribed verbatim by SD.

Analysis

Themes were identified from the transcribed interview data using Thematic Analysis as described by Braun and Clarke (2006). The analysis used an essentialist (realist) theoretical framework to reflect the experiences and meanings of the participants as they were articulated in the interview. NVivo software was used to organise and manage the data.

First, the data was read carefully to identify text segments relevant to the research questions. Second, segments of text were systematically given codes. The same segment of text could be given more than one code. Third, coded segments were sorted into potential themes. In order to successfully answer the specific research question, a broadly deductive approach was considered to be the most useful in forming the main themes. Therefore codes pertaining to the format and procedures of the CDG, perceived impact and usefulness and limitations or suggestions for improvement were identified and used to guide the process of generating themes. Finally, the themes were reviewed and refined to ensure they adequately capture the meaning of the data.

To ensure a degree of coherence and reliability of the themes, a second researcher (ML) independently coded and generated themes for a portion (25%) of the data and reviewed the final themes for a consensus to be reached.

Position of the Author

The primary author and data analyser (SD) was a trainee clinical psychologist with two years' experience working in an acute inpatient mental health ward. In the development of the study, SD

liaised closely with the psychologist facilitating the CDG (KC) and therefore had some ideas about the potential areas for development of the group prior to data collection.

Results

Within the three areas pertaining to the research question, eleven themes were identified, three within "The Group and how it operates" (Attendance, Discussion Topics and Facilitation), five within "Impact and Usefulness" (Valued by Staff, Understanding a Case, Emotional Benefit, Learning and Working together as a Team) and three within "Changes to the Group" (Organisation, Discussion Topic and Group Outcomes) (Table 2). Themes significant to the aims and objectives of the study are presented below.

<table 2 here>

The Group and how it operates

Three main themes were identified that related to the operation of the CDG: Attendance; Discussion Topics; and Facilitation.

Attendance

All participants discussed their attendance at the group. Staff tended to attend one session per month, with some staff able to attend fortnightly and the least frequent attendee just once in five months. Many aspects of the nature of inpatient ward work were suggested in preventing staff from being able to attend, including shift rotations and having cover for the ward.

> *P1: "…it's every other Thursday and if you are not working a Thursday you don't get to go."*
> *P6: "if you invite everyone in, then suddenly there is no one on the ward…. You can't really leave a 23 bed acute ward with no staff."*

Other barriers highlighted were being unaware that the group is scheduled (Participants 7, 10 and 11) and two participants suggested that there could be staff reticence due to a lack of knowledge of the purpose or the group or disinterest.

> *P8: "in a staff team you are gonna get a group of people who maybe have been here a long time and say "nothing stresses me, I don't need to go in" or "I don't need to do that, I'm alright" …in that way you get the same people coming in and the same people staying out and whether it's about education or something like that."*

This combination of factors resulted in different individuals being present at each group.

Discussion Topics

Eleven participants agreed that the main focus of CDGs was a clinical case from the ward. In particular, the emphasis was on complex or difficult cases where staff wanted ideas for their work.

> *P12: "…there are a few suggestions and we usually say the name which for us is maybe more difficult…most difficult person or, if behaviour of the person or patient is challenging really and it is good to discuss that person really. If everybody can get a better knowledge of how to actually treat the person."*
> *P9: "…the one that is most difficult, you know the most…that we are struggling the most with I suppose."*

Sometimes organisational issues such as management changes and staff relationships were discussed within CDG sessions (Participants 10 and 11) but this was acknowledged as being infrequent.

The choice of topic was decided through discussion at the start of a session with staff coming to an agreement (11 participants) but a few participants raised some difficulties with this process, namely spending too long trying to decide (Participant 1) and balancing the priorities of different team members (Participants 1, 6 and 7).

P1: "…I mean it's difficult isn't it…coz obviously there is 23 patients and everyone's got their own things that they want to deal with, especially now that we are in teams so you focus on your 7 or 8 patients…so stuff that I probably want to discuss with my patients, the other nurses wanna discuss their patients."

Impact and Usefulness

Responses relating to the ways in which participants found the group useful were organised into five main themes which were: Valued by Staff; Understanding a Case; Emotional Benefit; Learning; and Working together as a Team.

Understanding a Case

The benefits of coming together as a group to discuss and generate a greater understanding of a case were raised by all participants. In particular, participants talked about the group being an opportunity to hear different perspectives from the staff attending.

P3: "We come to a common understanding of the problem I guess, through putting all our ideas into the pot, and a richer understanding of the problem."

P7: "It can also provide a different perspective of the individual that is being discussed"

P1: "It's good that it's multi-disciplinary so you have all the nurses, the HCAs, OTs, ...psychology."

Hearing from all members of the team was valued, especially hearing from members that might otherwise lack opportunity to share their views such as Health Care Assistants (Participants 2, 3, 6 and 11). However, many of the Health Care Assistants included in this study identified some difficulties feeling able to contribute to the discussions.

P10: "I think if some of the other people aren't confident speaking in the groups, coz I know that there's a couple of us that aren't 100% about sharing stuff in the group, you might not get the benefit from it that you need. So you might not say what you are thinking or feeling, or you might not get chance to discuss a particularly area that you would like to, unless someone else brings it up."

In contrast to the view that it was helpful to gather different perspectives of a case, one participant indicated that the difference could be unhelpful.

P11: "the group sometimes I find have very individual views expressed which are not team views, which is something I am concerned about, that we work as a team, we need to see more of what the teams views are…what I am trying to say is polarised views sometimes exist and these groups can sometimes make that worse."

Although understanding a patient's difficulties was recognised as a key aspect of CDG, only three participants explicitly mentioned the use of psychological models and formulation as a process that was important in reaching this understanding.

P2: "…giving you different ways of how….of why a person might be feeling that way, and maybe going a little bit into formulation and looking at the reasons why they might do that, and that's good…it's like the whole of us talking about it, you can sort of gather a different picture."

P1: "So it's all transference and counter-transference…."

P3: "…if we don't do it we find that splits within the individual patients on the ward get acted out amongst us

Emotional Benefit

Eleven participants talked about the emotional benefits of attending the group. Talking about the way that they are feeling about a particular issue seemed to be important for staff members' own emotional wellbeing. Seven participants identified that the most helpful thing about sharing emotions was having these validated and acknowledged by colleagues.

P2: "I think that it's not….you know it doesn't go back onto the way we practise, but we relieve…it's that validation of someone listening to you and understanding you that it's frustrating and I think it gives us opportunity to look at other ways of, how we feel about it…."

The CDG sessions provided staff with an opportunity to support one another with the difficult nature of the work (six participants).

P1: "…but also it just made me feel better, better about my job, not necessarily making me a better nurse, or nurse that person in a different way, just sort of supportive."

Working together as a team

There was discussion from all participants about the ways in which the CDG enabled them to work together to get the best outcomes for patients, six of whom gave specific examples. It was acknowledged that ideally the group would lead to an agreement about how to approach patient care and "come up with a solution" (participant 8), but over half of participants suggested that the group did not manage to achieve this outcome for patients.

P1: "but yeah we never come out of CDG with like a strategy or a plan or anything like that. Not in the ones that I have been in anyway."

P2: "but I don't know how much we take on of it afterwards as such….as how we then deal with patients as such, I think that's maybe something we need to look at."

P8: "I think it feels a bit diluted when someone comes out of the group says "oh well what we should be doing is this."

It seemed important to disseminate the information and outcomes from the group sessions with other staff involved in the patient's care. Some participants thought that a summary would be documented in clinical notes or minutes from the meeting (Participants 2, 3, 6, 7 and 8) whereas others highlighted that those staff not in attendance would usually not be made aware of the information.

P3:" I think sometimes we forget. Because it's one more thing to do, we are all busy."

P5: "They don't have to hand over that actually I spoke to her slightly differently or I did that...so again that's the sort of thing that will just get passed, that will just get brushed under the carpet coz it's so… 'cause it seems so busy and sort of not as important"

P9: "I think it can get lost though, with it only being a few members of the team here and then if it's not handed over sufficiently then you know, we need to be working as a team and I think that that cannot always go as well as it should do here."

Changes to the group

All participants made suggestions for changes that could be made to improve the CDG: Organisation; Discussion Topic; and Group Outcomes.

Organisation

The need for more frequent CDGs was a common response to questions about change.

P2: "I think weekly would be great, even if we all couldn't go in weekly. It's a shame that we don't have psychology input on a constant basis really."

But one participant felt that they were too frequent.

P11: "although it is helpful, they should talk about that in their supervision, rather than use the valuable clinical psychology time when we are so under resourced for psychology on the ward."

Promoting the group to ensure that all staff are aware of not only the presence and schedule of the sessions, but also have an accurate understanding of the purpose and aims was suggested as a way of increasing participation.

P8: "I think it's about that education isn't it, that actually it's more about, well not solely about coming in a talking about what is stressing me out, it's about finding a solution and finding a way of dealing with that. It's not…it's a group thing, it's not a personal kind of…."how are we gonna help you then", it's about… ….promoting the idea that it's kind of patient centred and that it's for the benefit of the actual patients. And I think sometimes the focus goes away from that kind of thing and all the people that don't come to the meeting don't feel that that is what it's there for."

Five participants wanted to expand on the involvement of different professional groups, particularly medics, and wanted more involvement of psychology on the ward.

P3: "I think it would be very nice if the consultants came in more, they don't come in enough, only occasionally."

P2: "So I can see the benefit of it and I think that the perception is that in the acute phase psychology isn't helpful, and that's actually not true, it can be helpful and I know that within other trusts, they have psychology input a lot more than our trust do and I think that maybe that is something that we are lacking really."

Discussion Topic

Although participants had agreed that discussing complex and difficult cases was important, one participant (Participant 5) raised an idea that less prominent "under the radar" cases should have more attention within CDG as there could be scope for helpful approaches that might normally be overlooked.

With regard to selecting topics, four participants wanted to consider choosing the topic before the session to save time and also bring more information about the case to the session.

P8: "if we were to say that well OK then these people are going into the meeting, print off the formulation from [electronic notes], and you have got the first ¼ of an hour done, if you know what I mean, so now we can get on with the nitty gritty."

Outcome from the Group

Seven participants thought that more emphasis could be put on using the group discussions to inform patient care. Provision for following up a case discussion was also mentioned to ensure that the group is having an impact on staff work.

P11: "…we need to look at more of what would help, what are the things that will help this person be discharged from hospital and how they can maintain safety or whatever it is, so that those sort of things need to be discussed from the start."

P7: "I guess it would be helpful if we could agree on consequences for dealing with certain behaviours, establishing a sense of continuity."

P10: "possibly a follow up to it, rather than just doing the odd one. Coz sometimes you don't get enough time to talk about things as well."

The impact of the group on patient care was limited by the small number of staff able to attend any one session. Five participants suggested that it would be helpful to have a system for sharing session outcomes with the entire ward team to enhance consistency and enable the staff to work better together as a team.

> *P9: "...if there was someone who would have time to write up what had happened and email everyone what we had discussed. That would be useful, a little summary. Umm...yeah, you know, coz it does seem a bit pointless to have a discussion and then nothing comes of it."*

Discussion

This study aimed to determine the extent to which the evidence based components of effective supervision were met by a Clinical Discussion Group on an acute inpatient mental health ward. The findings demonstrate that multidisciplinary team supervision in the form of a CDG can be a successful and valuable way of bringing members of different professions together to enhance patient care. Previous literature highlighted that this approach can be challenging for supervisees (Hyrkäs and Appelqvist-Schmidlechner, 2003), so this study sought participants' views to find out what aspects of effective supervision are evidenced in the CDG, and to develop guidelines to improve the impact this group has on patient care.

Components of Effective Supervision in the Clinical Discussion Group

The group sessions took place fortnightly and were of 45 minutes duration. Many participants viewed this as inadequate given shift rotations, the potential number of cases to discuss and limited direct psychological input for patients. This is supported by previous research which suggests that more frequent supervision has a greater impact on the work of supervisees (Buus et al., 2011, Gonge and Buus, 2011) with recommendations of hourly sessions at least monthly (Edwards et al., 2005).

As in previous research (Christofides et al., 2012, Mullarkey et al., 2001), most participants commented that the group had many benefits. There was however a disparity between this perspective and the view of one participant who felt that the group was an unhelpful use of a psychologist's time and therefore should be reduced, which appeared to be a result of a misinterpretation of the purpose and aims of the group. This particular participant had thought the group was for staff to make complaints and discuss their disagreements rather than focus on case understanding and patient care. It is possible that this misunderstanding prevents some clinicians from attending. This raises the importance of promoting the aims of CDGs and providing an evidence base for the benefits of team formulation based supervision.

Supervisee involvement in the planning and preparation for sessions has been identified as an important component of supervision (Aston and Molassiotis, 2003, Kavanagh et al., 2002, Sloan, 1999). However, the results here showed that although staff took responsibility for choosing a case for discussion, there was no preparation in advance of the sessions and rarely was the summary and outcome documented. Some participants acknowledged that this was an inefficient use of time and suggested that more preparation, although difficult in a busy ward environment, would be a valuable change. For staff to capitalise on the time spent in group supervision (e.g. CDG) resources should be set aside to allow for agenda setting, preparation, documentation and dissemination.

Coming together to discuss a complex case enabled the majority of participants in this study to develop a better understanding of a patient's difficulties. Group case discussion for multidisciplinary teams such as the CDG have an additional advantage of drawing upon many more different personal and professional perspectives in order to come to a useful understanding. A substantial literature indicates that supervision is most successful when it is based upon theoretically informed formulations (Milne

et al., 2011, Gonge and Buus, 2011, Berry et al., 2009). However, only three of the twelve participants described how psychological theories and models could be used to produce a formulation, which indicates that this process was not explicit within then CDG. For group supervision to be effective, psychological theories and models need to be used explicitly in order to enhance understanding of a case, and enable participants to generalise their learning and apply their knowledge when working with other patients..

The collaborative understanding helped staff in this study to remain empathic toward patients in the face of challenging behaviours and maintain a sense of hopefulness in their work. A supportive supervision environment has been described as essential for psychiatric nurses to aid them in coping with the emotional difficulties of their work (Buus et al., 2011, Scanlon and Weir, 1997). These benefits of supervision have been acknowledged previously as normative functions according to Proctor's (1987) model and evidenced by Brunero and Stein-Parbury (2008) and Severinsson and Hallberg (1996) who found that staff-patient relationships were improved as a result.

The intention of the CDG was to enable staff to use the new understanding to solve problems in their work and provide effective interventions for patients. Six participants were able to identify occasions where a care plan was put forward and implemented but many others spoke about the group having little impact on their practice. This is a concerning finding given that inpatient ward staff are required to work intensively with patients and often have limited opportunities for supervision beyond discussion groups.

Clinical Implications

Adequate frequency, a well-defined purpose, and preparation for sessions are aspects of supervision deemed to be essential by the Division of Clinical Psychology (Division of Clinical Psychology, 2014). In their policy on supervision, formalised supervision contracts are advocated to make clear the function, format and responsibilities of each member. Multidisciplinary team supervision as described in this study may not lend itself to this form of contract, but a documented version of the aims, purpose, arrangements, format and member responsibilities would be good practice, would resolve the misunderstandings identified in this research and would help orientate new team members to the approach.

For multidisciplinary team supervision to be effective in introducing evidence driven interventions, emphasis must be placed on actively using the conceptualisation achieved through case discussion. In an inpatient ward environment, this presents many challenges as staff rotations, time restrictions and demanding workloads often overshadow the advances made in supervision sessions. This study would suggest that time set aside to plan the actions to be taken, including how to share the information with staff who were unable to be present, would be a helpful approach to CDGs. Furthermore, CDG's should aim to revisit and review actions from previous sessions in order to facilitate learning which would enable staff to generalise their understanding of one case to situations in the future and ensure the longer term development of service provision. Dexter-Smith (2010) provides an excellent framework for team formulation based supervision using a cognitive-behavioural model demonstrating that it is possible to engender a psychologically informed team approach to inpatient working.

Strengths and Limitations

This study explored the views of a diverse range of participants including representatives from each profession within the multidisciplinary team. There may however be some sampling bias given that participation was voluntary and staff members who did not attend the group, or held more negative

views of its purpose and usefulness, may have been less likely to participate. The study sought to encourage everyone to participate, regardless of their views and provided individual interviews rather than focus groups to offer an opportunity to be honest and uninhibited by colleagues who may hold different views.

A strength of this research is the credibility checks, using a second analyst to code a portion (25%) of the transcripts and identify themes. The final themes were consistent with those identified within the credibility sample. Furthermore, data saturation was reached with no new themes being identified. Although this indicates a degree of reliability and validity for these results, it is important to note that this study explored the views of staff members from a single acute mental health inpatient ward and therefore the findings may not be generalizable to other settings, although they are consistent with findings in the wider supervision literature.

Future Directions

This study has highlighted themes that should be considered for offering supervision in the form of multidisciplinary case discussion groups for staff working in acute inpatient mental health services. Suggestions for good practice are summarised in Table 3.

<Table 3 here>

This research has explored the implementation and challenges of a CDG from the perspective of the staff who attend. Although this has generated some ideas for improving the impact of this form of supervision on patient outcomes, further research is needed to objectively measure this. One method of achieving this was described by Green (1999) who employed a "critical incident analysis" methodology (Kemppainen, 2000) to measure staff behavioural changes following supervision. CDG's should in the future aim to develop and routinely use outcome measures in order to evaluate their efficacy and justify their importance within acute inpatient mental health services.

References

ARVIDSSON, B., BAIGI, A. & SKARSATER, I. 2008. Changes in the effects of process-oriented group supervision as reported by female and male nursing students: a prospective longitudinal study. *Scandinavian Journal of Caring Sciences,* 22**,** 437-444.

ASTON, L. & MOLASSIOTIS, A. 2003. Supervising and supporting student nurses in clinical placements: the peer support initiative. *Nurse Education Today,* 23**,** 202-210.

BERG, A. & HALLBERG, I. R. 1999. Effects of systematic clinical supervision on psychiatric nurses' sense of coherence, creativity, work-related strain, job satisfaction and view of the effects from clinical supervision: a pre-post test design. *J Psychiatr Ment Health Nurs,* 6**,** 371-81.

BERG, A., HANSSON, U. W. & HALLBERG, I. R. 1994. Nurses' creativity, tedium and burnout during 1 year of clinical supervision and implementation of individually planned nursing care: comparisons between a ward for severely demented patients and a similar control ward. *J Adv Nurs,* 20**,** 742-9.

BERRY, K., BARROWCLOUGH, C. & WEARDEN, A. 2009. A Pilot Study investigating the Use of Psychological Formulations to Modify Psychiatric Staff Perceptions of Service users with Psychosis. *Behavioural and Cognitive Psychotherapy,* 37**,** 39-48.

BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology,* 3**,** 77-101.

BRITISH PSYCHOLOGICAL SOCIETY 2001. Working in Teams. British Psychological Society.

BRUNERO, S. & STEIN-PARBURY, J. 2008. The effectiveness of clinical supervision in nursing: an evidenced based literature review. *Australian Journal of Advanced Nursing,* 25**,** 86-94.
BUTTERWORTH, T., BELL, L., JACKSON, C. & PAJNKIHAR, M. 2008. Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007. *Nurse Education Today,* 28**,** 264-272.
BUUS, N., ANGEL, S., TRAYNOR, M. & GONGE, H. 2011. Psychiatric nursing staff members' reflections on participating in group-based clinical supervision: a semistructured interview study. *Int J Ment Health Nurs,* 20**,** 95-101.
BUUS, N. & GONGE, H. 2009. Empirical studies of clinical supervision in psychiatric nursing: A systematic literature review and methodological critique. *Int J Ment Health Nurs,* 18**,** 250-64.
CHRISTOFIDES, S., JOHNSTONE, L. & MUSA, M. 2012. 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice,* 85**,** 424-435.
CROWE, M., CARLYLE, D. & FARMAR, R. 2008. Clinical formulation for mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing,* 15**,** 800-807.
DAVENPORT, S. 2002. Acute wards: Problems and solutions. *Psychiatric Bulletin,* 26**,** 385-388.
DEXTER-SMITH, S. 2010. Integrating psychological formulations into older people's services – three years on (Part 1). *PSIGE Newsletter,* 112**,** 8-11.
DIVISION OF CLINICAL PSYCHOLOGY 2014. DCP Policy on Supervision. British Psychological Society.
EDWARDS, D., BURNARD, P., HANNIGAN, B., COOPER, L., ADAMS, J., JUGGESSUR, T., FOTHERGIL, A. & COYLE, D. 2006. Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *J Clin Nurs,* 15**,** 1007-15.
EDWARDS, D., COOPER, L., BURNARD, P., HANNIGAN, B., JUGGESUR, T., ADAMS, J., FOTHERGILL, A. & COYLE, D. 2005. Factors influencing the effectiveness of clinical supervision. *J Psychiatr Ment Health Nurs,* 12**,** 405-14.
GONGE, H. & BUUS, N. 2011. Model for investigating the benefits of clinical supervision in psychiatric nursing: A survey study. *International Journal of Mental Health Nursing,* 20**,** 102-111.
GREEN, A. 1999. A utilisation-focused evaluation of a clinical supervision programme for nurses and health visitors in one national health service trust. *Journal of Vocational Education & Training,* 51**,** 493-505.
HALLBERG, I. R. 1994. Systematic clinical supervision in a child psychiatric ward: satisfaction with nursing care, tedium, burnout, and the nurses' own report on the effects of it. *Arch Psychiatr Nurs,* 8**,** 44-52.
HALLBERG, I. R. & NORBERG, A. 1993. Strain among nurses and their emotional reactions during 1 year of systematic clinical supervision combined with the implementation of individualized care in dementia nursing. *J Adv Nurs,* 18**,** 1860-75.
HALLBERG, I. R., WELANDER-HANSSON, U. & AXELSSON, K. 1994. Satisfaction with nursing care and work during a year of clinical supervision and individualised care. Comparison between a ward for care of severely demented patients and similar control ward. *Journal of Nursing Management,* 1**,** 297-307.
HYRKAS, K. 2005. Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues Ment Health Nurs,* 26**,** 531-56.
HYRKÄS, K. & APPELQVIST-SCHMIDLECHNER, K. 2003. Team supervision in multiprofessional teams: team members' descriptions of the effects as highlighted by group interviews. *Journal of Clinical Nursing,* 12**,** 188-97.
JOHNSTONE, L. & DALLOS, R. 2006. Introduction to formulation. *Formulation in psychology and psychotherapy: Making sense of people's problems***,** 1-16.

KAVANAGH, D. J., SPENCE, S. H., WILSON, J. & CROW, N. 2002. Achieving effective supervision. *Drug and Alcohol Review,* 21**,** 247-252.
KEMPPAINEN, J. K. 2000. The critical incident technique and nursing care quality research. *J Adv Nurs,* 32**,** 1264-71.
KENNEDY, F., SMALLEY, M. & HARRIS, T. 2003. Clinical psychology for in-patient settings: Principles for development and practice. *Clinical Psychology Forum,* 30**,** 21-24.
KOLB, D. A. 1984. *Experiential learning: Experience as the source of learning and development*, Prentice-Hall Englewood Cliffs, NJ.
LAKE, N. 2008. Developing skills in consultation 2: A team formulation approach. *Clinical Psychology Forum,* 186**,** 18-24.
MARTIN, E. & MILTON, A. 2005. Working systemically with residential home staff. *Context,* 77**,** 37-9.
MILNE, D. L. 2007. An empirical definition of clinical supervision. *British Journal of Clinical Psychology,* 46**,** 437-447.
MILNE, D. L., SHEIKH, A. I., PATTISON, S. & WILKINSON, A. 2011. Evidence-based training for clinical supervisors: A systematic review of 11 controlled studies. *The Clinical Supervisor,* 30**,** 53-71.
MULLARKEY, K., KEELEY, P. & PLAYLE, J. 2001. Multiprofessional clinical supervision: challenges for mental health nurses. *Journal of Psychiatric and Mental Health Nursing,* 8**,** 205-211.
NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND 2007. *Mental health: New ways of working for everyone*, Department of Health.
PROCTOR, B. 1987. A co-operative exercise in accountability. *In:* MARKEN, M. & PAYNE, M. (eds.) *Enabling and Ensuring — Supervision in Practice.* Leicester: National Youth Bureau Council for Education and Training in Youth and Community Work.
SCANLON, C. & WEIR, W. S. 1997. Learning from practice? Mental health nurses' perceptions and experiences of clinical supervision. *Journal of Advanced Nursing,* 26**,** 295-303.
SEVERINSSON, E. I. & HALLBERG, I. R. 1996. Systematic clinical supervision, working milieu and influence over duties: The psychiatric nurse's viewpoint - A pilot study. *International Journal of Nursing Studies,* 33**,** 394-406.
SLOAN, G. 1999. Good characteristics of a clinical supervisor: A community mental health nurse perspective. *Journal of Advanced Nursing,* 30**,** 713-722.
SUMMERS, A. 2006. Psychological formulations in psychiatric care: staff views on their impact. *Psychiatric Bulletin,* 30**,** 341-343.